VERIFICATION OF MOBILITY, VISION, OR HEARING DISABILITY

#2239

Applicant Head of Household name: _____

Name of household member who has a mobility, vision or hearing disability:

#2239 _____ **DOB:** [redacted]52

Relationship to Applicant/Head of Household: _____

The Applicant/Head of Household is seeking to be deemed eligible for a dwelling unit that is accessible or can be adapted for use by an individual who has mobility, vision, or hearing disability. A federal law, Section 504 of the Rehabilitation Act, requires that a certain percentage of dwelling units in this development be set aside for households that need such units. A licensed medical doctor must confirm the existence of a qualifying disability of a household member in order for the household to be considered for one of these accessible/adaptable units.

In your professional medical opinion:

1. Does the named household member use a wheelchair or is s/he otherwise mobility disabled? X yes ____ no

2. If yes, is the mobility disability expected to continue for at least 12 months or be of infinite duration? X yes ____ no

3. Is the named household member hearing disabled to such a degree that s/he would benefit from a unit for people with a hearing disability (a unit that is equipped with strobe light smoke alarm and doorbell)?

____ yes X no

4. Is the named household member vision disabled to such a degree that s/he would benefit from a unit for people with a vision disability (a unit that is equipped with Braille stove and thermostat markings)?

____ yes X no

I swear/affirm under penalty of perjury that the information above is accurate and true.

Name: EinGoss Title: MD

Signature: [signature] Date: 5/24/17

Address: 305 E 161st St Bronx NY 10451 Telephone number: (718) 579 2500

License number: 264827

Stamp:

MONTEFIORE MEDICAL GROUP
305 East 161st Street
Bronx, New York 10451
Tel. (718) 579-2500
Fax (718) 579-2599

CERTIFICATION OF ELIGIBILITY FOR DISABILITY SET ASIDE UNIT

Date: May 29, 2017

#2239

Applicant Head of Household name: [redacted]

Phone number: [redacted]

Current address: [redacted] New York [redacted]

This form should be used by applicants who have been selected for an interview and who have indicated on the application that they need a unit that is accessible or adaptable for a mobility-disabled household member or a household member with vision or hearing disability.

The applicant must complete the first page of this form and have a medical doctor complete the second page. The applicant should give both pages to the developer at the interview for the apartment.

Name of household member who has a mobility, vision or hearing disability:

#2239

Relationship to Applicant: Self

1. Does the named household member use a wheelchair or is s/he otherwise mobility disabled? ✓ yes ____ no

2. If yes, is the mobility disability expected to continue for at least 12 months or longer?
✓ yes ____ no (Uses Cane)

3. Is s/he hearing disabled? ____ yes ✓ no

4. Is s/he vision disabled? ____ yes ✓ no

I certify that the above statements are true to the best of my knowledge. I understand that supplying false information may lead to the denial of my housing application. I authorize the developer and the Department of Housing Preservation and Development of the City of New York (HPD) or the New York City Housing Development Corporation (HDC) to verify my eligibility with my medical doctor and I authorize my doctor to provide such verification to the developer and HPD/HDC, on their request.

Signature of household member who has a mobility, vision, or hearing disability:

#2239

_____ (or parent or legal guardian if under 18)

May 29, 2017 (date)

525 W. 52ND STREET APTS

HANCOCK APTS 350 W. 124TH STREET, NEW YORK, NY 10027 TEL: (646) 388-8329 FAX: (212) 866-1912

DISABLED VERIFICATION

Date: 07/17/2017 Log.# 2911

To: ATTN: Karen L. Morice, MD
Department of Rehabilitation Medicine
111 E. 210th st Bronx, NY 10467-2401

RE: 2911
SS#/Tax I.D. #: [redacted]

The individual named directly above is an applicant/tenant of a housing program that requires verification of income. We ask that you complete and return this form as soon as possible or fax: (212) 866-1912. The information will be used only in determining eligibility for this particular program. It will not be made available to anyone else. Your prompt response is crucial and greatly appreciated.

If you have any questions, please call our office at tel.: (646) 388-8329

Sincerely,

525 W. 52ND STREET APTS

****

AUTHORIZATION:

I hereby authorize release of the [illegible] nation requested on this verification form.

2911

Signature of Applicant / Tenant [redacted] Date 07/17/2017

INFORMATION BEING REQUESTED:
CERTIFICATE OF DISABILITY:

A person who is disabled to the extent of being unable to engage in any substantial gainful activity by reason of any medically determinable Mobility, Visual, and Hearing impairment which has lasted or can be expected to last for a continuous period of not less that twelve months.

In my opinion, the above-named person does (does, does not) have a mobility (Mobility, Visual and Hearing impairment) as defined above.

Evaluator/Diagnostician Name: Karen Morice MD

Title: Attending physician Signature: KMorice

7-20-17 Date

718-547-4940 Telephone Number

EQUAL HOUSING OPPORTUNITY

Log # 2911

VERIFICATION OF MOBILITY, VISION, OR HEARING DISABILITY

Applicant Head of Household name: 2911 _____

Name of household member who has a mobility, vision or hearing disability:

2911 _____ DOB: [redacted] 1958

Relationship to Applicant/Head of Household: self

The Applicant/Head of Household is seeking to be deemed eligible for a dwelling unit that is accessible or can be adapted for use by an individual who has mobility, vision, or hearing disability. A federal law, Section 504 of the Rehabilitation Act, requires that a certain percentage of dwelling units in this development be set aside for households that need such units. A licensed medical doctor must confirm the existence of a qualifying disability of a household member in order for the household to be considered for one of these accessible/adaptable units.

In your professional medical opinion:

1. Does the named household member use a wheelchair or is s/he otherwise mobility disabled? ✓ yes ____ no

2. If yes, is the mobility disability expected to continue for at least 12 months or be of infinite duration? ✓ yes ____ no

3. Is the named household member hearing disabled to such a degree that s/he would benefit from a unit for people with a hearing disability (a unit that is equipped with strobe light smoke alarm and doorbell)?

____ yes ✓ no

4. Is the named household member vision disabled to such a degree that s/he would benefit from a unit for people with a vision disability (a unit that is equipped with Braille stove and thermostat markings)?

____ yes ✓ no

I swear/affirm under penalty of perjury that the information above is accurate and true.

Name: Karen Morice MD Title: Physician

Signature: [signature] Date: 7-6-17

Address: 111 E. 210th St, Bronx, NY 10467 Telephone number: ( ) 718-920-4133

License number: 247735

Stamp: N/A

Log # 2911

CERTIFICATION OF ELIGIBILITY FOR DISABILITY SET ASIDE UNIT

Date: 07/11/17

2911

Applicant Head of Household name _____

Phone number: [redacted]

Current address: [redacted]

BX, New York [redacted]

This form should be used by applicants who have been selected for an interview and who have indicated on the application that they need a unit that is accessible or adaptable for a mobility-disabled household member or a household member with vision or hearing disability.

The applicant must complete the first page of this form and have a medical doctor complete the second page. The applicant should give both pages to the developer at the interview for the apartment.

Name of household member who has a mobility, vision or hearing disability:

_____ 2911 _____

Relationship to Applicant: [redacted] Self

1. Does the named household member use a wheelchair or is s/he otherwise mobility disabled? ✓ yes ____ no

2. If yes, is the mobility disability expected to continue for at least 12 months or longer?

✓ yes ____ no

3. Is s/he hearing disabled? ____ yes ✓ no

4. Is s/he vision disabled? ____ yes ✓ no

I certify that the above statements are true to the best of my knowledge. I understand that supplying false information may lead to the denial of my housing application. I authorize the developer and the Department of Housing Preservation and Development of the City of New York (HPD) or the New York City Housing Development Corporation (HDC) to verify my eligibility with my medical doctor and I authorize my doctor to provide such verification to the developer and HPD/HDC, on their request.

Signature of household member who has a mobility, vision, or hearing disability:

2911

_____ (or parent or legal guardian if under 18)

07/11/17 [redacted] (date)

525 W. 52ND STREET APTS

HANCOCK APTS 350 W. 124TH STREET, NEW YORK, NY 10027 TEL: (646) 388-8329 FAX: (212) 866-1912

DISABLED VERIFICATION

Date: 8/22/17

To: Godwin Medical, PC
145 W 96 Street
New York, NY 100

Log. # 4382

RE: 4382

SS#/Tax I.D. #: [redacted]

The individual named directly above is an applicant/tenant of a housing program that requires verification of income. We ask that you complete and return this form as soon as possible or fax: (212) 866-1912. The information will be used only in determining eligibility for this particular program. It will not be made available to anyone else. Your prompt response is crucial and greatly appreciated.

If you have any questions, please call our office at tel.: (646) 388-8329

Sincerely,

525 W. 52ND STREET APTS

****

AUTHORIZATION:

I hereby authorize release of the information requested on this verification form.

4382 _____ Tenant

8/22/17 Date

INFORMATION BEING REQUESTED:

CERTIFICATE OF DISABILITY:

A person who is disabled to the extent of being unable to engage in any substantial gainful activity by reason of any medically determinable Mobility, Visual, and Hearing impairment which has lasted or can be expected to last for a continuous period of not less that twelve months.

In my opinion, the above-named person _____ (does, does not) have a _____ (Mobility, Visual and Hearing impairment) as defined above.

Evaluator/Diagnostician Name: Dx: 491.93 / 201.110 Hearing Loss Mixed

Title: MD

Signature: _____ 8/30/17

8/30/17 Date

Godwin Medical, PC
Dr. Clotilde Pena, MD
145 W 96th Street
New York, NY 10025
T: 212-663-3420
F: 347-587-4021

212 663-3420 Telephone Number

Godwin Medical, PC
Dr. Clotilde Pena, MD
145 W 96th Street
New York, NY 10025
T: 212-663-3420
F: 347-587-4021

EQUAL HOUSING OPPORTUNITY

LOG # 4382

VERIFICATION OF MOBILITY. VISION. OR HEARING DISABILITY

Applicant Head of Household name: __ 4382 _____

Name of household member who has a mobility, vision or hearing disability:

__ 4382 _____ DOB: [redacted]06

Relationship to Applicant/Head of Household: Son

The Applicant/Head of Household is seeking to be deemed eligible for a dwelling unit that is accessible or can be adapted for use by an individual who has mobility, vision, or hearing disability. A federal law, Section 504 of the Rehabilitation Act, requires that a certain percentage of dwelling units in this development be set aside for households that need such units. A licensed medical doctor must confirm the existence of a qualifying disability of a household member in order for the household to be considered for one of these accessible/adaptable units.

In your professional medical opinion:

1. Does the named household member use a wheelchair or is s/he otherwise mobility disabled? ____ yes ✓ no

2. If yes, is the mobility disability expected to continue for at least 12 months or be of infinite duration? ____ yes ✓ no

3. Is the named household member hearing disabled to such a degree that s/he would benefit from a unit for people with a hearing disability (a unit that is equipped with strobe light smoke alarm and doorbell)?

✓ ____ yes ____ no

4. Is the named household member vision disabled to such a degree that s/he would benefit from a unit for people with a vision disability (a unit that is equipped with Braille stove and thermostat markings)?

____ yes ✓ ____ no

I swear/affirm under penalty of perjury that the information above is accurate and true.

Name: Clotilde Pena Title: Pediatrician

Signature: _____ Date: 8/5/2017

Address: 145 W. 96 St. Suite 1c Telephone number: ( ) 212-663-3420

License number: 243960

Stamp:

Godwin Medical, PC
Dr. Clotilde Pena, MD
145 W 96th Street
New York, NY 10025
T: 212-663-3420
F: 347-587-4021

CERTIFICATION OF ELIGIBILITY FOR DISABILITY SET ASIDE UNIT

Date: 9/2/17

4382

Applicant Head of Household name: [redacted]

Phone number: [redacted]

Current address: [redacted]

NY, New York [redacted]

This form should be used by applicants who have been selected for an interview and who have indicated on the application that they need a unit that is accessible or adaptable for a mobility-disabled household member or a household member with vision or hearing disability.

The applicant must complete the first page of this form and have a medical doctor complete the second page. The applicant should give both pages to the developer at the interview for the apartment.

Name of household member who has a mobility, vision or hearing disability:

4382

Relationship to Applicant: Son

1. Does the named household member use a wheelchair or is s/he otherwise mobility disabled? ___ yes ✓ no

2. If yes, is the mobility disability expected to continue for at least 12 months or longer?

___ yes ___ no

3. Is s/he hearing disabled? ✓ yes ___ no

4. Is s/he vision disabled? ___ yes ✓ no

I certify that the above statements are true to the best of my knowledge. I understand that supplying false information may lead to the denial of my housing application. I authorize the developer and the Department of Housing Preservation and Development of the City of New York (HPD) or the New York City Housing Development Corporation (HDC) to verify my eligibility with my medical doctor and I authorize my doctor to provide such verification to the developer and HPD/HDC, on their request.

Signature of household member who has a mobility, vision, or hearing disability:

4382

[redacted] 9/2/17 (date)

___ (or parent or legal guardian if under 18)

4382

VERIFICATION OF MOBILITY, VISION, OR HEARING DISABILITY

Applicant Head of Household name: ____ 4723 _____

Name of household member who has a mobility, vision or hearing disability:

4723 _____ DOB: [redacted] /1956

Relationship to Applicant/Head of Household: Pain Management / Self

The Applicant/Head of Household is seeking to be deemed eligible for a dwelling unit that is accessible or can be adapted for use by an individual who has mobility, vision, or hearing disability. A federal law, Section 504 of the Rehabilitation Act, requires that a certain percentage of dwelling units in this development be set aside for households that need such units. A licensed medical doctor must confirm the existence of a qualifying disability of a household member in order for the household to be considered for one of these accessible/adaptable units.

In your professional medical opinion:

1. Does the named household member use a wheelchair or is s/he otherwise mobility disabled? ____ yes ____ no

2. If yes, is the mobility disability expected to continue for at least 12 months or be of infinite duration? ____ yes ____ no

3. Is the named household member hearing disabled to such a degree that s/he would benefit from a unit for people with a hearing disability (a unit that is equipped with strobe light smoke alarm and doorbell)?

____ yes ____ no

4. Is the named household member vision disabled to such a degree that s/he would benefit from a unit for people with a vision disability (a unit that is equipped with Braille stove and thermostat markings)?

____ yes ____ no

I swear/affirm under penalty of perjury that the information above is accurate and true.

Name: Jessica Au Title: M.D.

Signature: _____ Date: 7/26/17

Address: 369 East 149th St 9th FL Telephone number: ( ) ___-_____

License number: 269781 718-401-1111

Stamp:

4723 Scan on 8/2/2017 by Rebecca Gonzalez [REG2017] of Verification of Mobility, Vision, Hearing Form- C

4723 Scan on 8/2/2017 by Peter Alphonso of Verification of Mobility, Vision, and Hearing Form

VERIFICATION OF MOBILITY, VISION, OR HEARING DISABILITY

4723

Applicant Head of Household name: _____

Name of household member who has a mobility, vision or hearing disability:

4723 _____ DOB: [redacted]56

Relationship to Applicant/Head of Household: Brother

The Applicant/Head of Household is seeking to be deemed eligible for a dwelling unit that is accessible or can be adapted for use by an individual who has mobility, vision, or hearing disability. A federal law, Section 504 of the Rehabilitation Act, requires that a certain percentage of dwelling units in this development be set aside for households that need such units. A licensed medical doctor must confirm the existence of a qualifying disability of a household member in order for the household to be considered for one of these accessible/adaptable units.

In your professional medical opinion:

1. Does the named household member use a wheelchair or is s/he otherwise mobility disabled? ✓ yes ___ no

2. If yes, is the mobility disability expected to continue for at least 12 months or be of infinite duration? ✓ yes ___ no

3. Is the named household member hearing disabled to such a degree that s/he would benefit from a unit for people with a hearing disability (a unit that is equipped with strobe light smoke alarm and doorbell)?

___ yes ✓ no

4. Is the named household member vision disabled to such a degree that s/he would benefit from a unit for people with a vision disability (a unit that is equipped with Braille stove and thermostat markings)?

___ yes ✓ no

I swear/affirm under penalty of perjury that the information above is accurate and true.

Name: Judy Tung Title: MD

Signature: _____ Date: 8/2/17

Address: 505 E 70th St Telephone number: (212) 746-5858

License number: 216747

Stamp: Weill Cornell Physician's Offices
Dept. of Medicine
156 William Street, 7th Floor
New York, NY 10038

CERTIFICATION OF ELIGIBILITY FOR DISABILITY SET ASIDE UNIT

Date: 8/1/2017

4723

Applicant Head of Household name: [redacted]

Phone number: [redacted]

Current address: [redacted]

BRONX, New York [redacted]

This form should be used by applicants who have been selected for an interview and who have indicated on the application that they need a unit that is accessible or adaptable for a mobility-disabled household member or a household member with vision or hearing disability.

The applicant must complete the first page of this form and have a medical doctor complete the second page. The applicant should give both pages to the developer at the interview for the apartment.

Name of household member who has a mobility, vision or hearing disability:

4723

Relationship to Applicant: Self

1. Does the named household member use a wheelchair or is s/he otherwise mobility disabled? ✓ yes ____ no

2. If yes, is the mobility disability expected to continue for at least 12 months or longer?

✓ yes ____ no

3. Is s/he hearing disabled? ____ yes ✓ no

4. Is s/he vision disabled? ____ yes ✓ no

I certify that the above statements are true to the best of my knowledge. I understand that supplying false information may lead to the denial of my housing application. I authorize the developer and the Department of Housing Preservation and Development of the City of New York (HPD) or the New York City Housing Development Corporation (HDC) to verify my eligibility with my medical doctor and I authorize my doctor to provide such verification to the developer and HPD/HDC, on their request.

Signature [redacted] household member who has a mobility, vision, or hearing disability:

4723

_____ (or parent or legal guardian if under 18)

[redacted]8/1/2017 (date)

9/15/2017 2:39 PM FROM: Fax GROUPO MEDICO DOMINICANO TO: 12128661912 PAGE: 002 OF 003

525 W. 52ND STREET APTS [redacted] 1926
HANCOCK APTS 350 W. 124TH STREET, NEW YORK, NY 10027 TEL: (646) 388-8329 FAX: (212) 866-1912

DISABLED VERIFICATION

Date: 9/12/17

To: Gladstone Gunns
629 W 185 Street
New York, NY 10033

Log. # 5804

RE: 5804

SS#/Tax I.D. #: [redacted]

The individual named directly above is an applicant/tenant of a housing program that requires verification of income. We ask that you complete and return this form as soon as possible or fax: (212) 866-1912. The information will be used only in determining eligibility for this particular program. It will not be made available to anyone else. Your prompt response is crucial and greatly appreciated.

If you have any questions, please call our office at tel.: (646) 388-8329

Sincerely,

525 W. 52ND STREET APTS

****

AUTHORIZATION:

I hereby authorize release of the information requested on this verification form.

X 5804
Signature of Applicant/Tenant

9/12/17
Date

INFORMATION BEING REQUESTED:

CERTIFICATE OF DISABILITY:

A person who is disabled to the extent of being unable to engage in any substantial gainful activity by reason of any medically determinable Mobility, Visual, and Hearing Impairment which has lasted or can be expected to last for a continuous period of not less that twelve months.

5804[redacted]

In my opinion, the above-named person (does) does not) have a _____ (Mobility, Visual and Hearing Impairment) as defined above.

Evaluator/Diagnostician Name: Martha M. Valdivia, MD
Lic. #198167
NPI #1083646970

Title: _____

Signature: [signature]

9/15/17
Date

(212) 928-3900
Telephone Number

Equal Housing Opportunity

VERIFICATION OF MOBILITY, VISION, OR HEARING DISABILITY

Applicant Head of Household name: 5804

Name of household member who has a mobility, vision or hearing disability:
5804 DOB: [redacted]26

Relationship to Applicant/Head of Household: mother

The Applicant/Head of Household is seeking to be deemed eligible for a dwelling unit that is accessible or can be adapted for use by an individual who has mobility, vision, or hearing disability. A federal law, Section 504 of the Rehabilitation Act, requires that a certain percentage of dwelling units in this development be set aside for households that need such units. A licensed medical doctor must confirm the existence of a qualifying disability of a household member in order for the household to be considered for one of these accessible/adaptable units.

In your professional medical opinion:

1. Does the named household member use a wheelchair or is s/he otherwise mobility disabled? ✓ yes ____ no

2. If yes, is the mobility disability expected to continue for at least 12 months or be of infinite duration? ✓ yes ____ no

3. Is the named household member hearing disabled to such a degree that s/he would benefit from a unit for people with a hearing disability (a unit that is equipped with strobe light smoke alarm and doorbell)?

____ yes ✓ no

4. Is the named household member vision disabled to such a degree that s/he would benefit from a unit for people with a vision disability (a unit that is equipped with Braille stove and thermostat markings)?

____ yes ✓ no

I swear/affirm under penalty of perjury that the information above is accurate and true.

Name: Gladstone L. Guniss Lic. #002809-1 NPI #1851532477 Title: RNA

Signature: CENTRO MEDICO D[illegible] CANO Date: 7/31/17

Address: 629 WEST 185th STREET NEW YORK, NY 10033 Telephone number: ( ) 212 928 3900

License number: 002801

Stamp: CENTRO MEDICO D[illegible] CANO
629 WEST 185th STREET
NEW YORK, NY 10033

CERTIFICATION OF ELIGIBILITY FOR DISABILITY SET ASIDE UNIT

Date: 8/10/17 5804 ____

Applicant Head of Household name: [redacted]

Phone number: [redacted]

Current address: [redacted]

New York, New York [redacted]

This form should be used by applicants who have been selected for an interview and who have indicated on the application that they need a unit that is accessible or adaptable for a mobility-disabled household member or a household member with vision or hearing disability.

The applicant must complete the first page of this form and have a medical doctor complete the second page. The applicant should give both pages to the developer at the interview for the apartment.

Name of household member who has a mobility, vision or hearing disability:

5804 5804 ____

Relationship to Applicant: Mother

1. Does the named household member use a wheelchair or is s/he otherwise mobility disabled? ✓ yes ____ no

2. If yes, is the mobility disability expected to continue for at least 12 months or longer?

✓ yes ____ no

3. Is s/he hearing disabled? ____ yes ✓ no

4. Is s/he vision disabled? ✓ yes ____ no

I certify that the above statements are true to the best of my knowledge. I understand that supplying false information may lead to the denial of my housing application. I authorize the developer and the Department of Housing Preservation and Development of the City of New York (HPD) or the New York City Housing Development Corporation (HDC) to verify my eligibility with my medical doctor and I authorize my doctor to provide such verification to the developer and HPD/HDC, on their request.

Signature of household member who has a mobility, vision, or hearing disability:

5804 5804 ____ (or parent or legal guardian if under 18)

8/10/17 (date)